Referring Provider: _____

Reason For Visit: _____

Primary Care Provider: _____

Patient Name: _____ Birth Date:_____

Social Security Number: _____ Gender: Male Female

Address: _____

Cell Phone # _____ Home Phone # _____

Work Phone # _____

Email: _____

Marital Status: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone: _____ Email: _____

Insurance Information

Primary Insurance:

Primary Company: _____ Insured's Name: _____

Policy: _____ Group:_____ Insured's DOB: _____

Secondary Insurance:

Primary Company:_____ Insured's Name: _____

Policy #: _____ Group #:_____ Insured's DOB: _____

Self- Pay Agreement:

I agree to pay for medical services from David S. Hernandez MD, PA. I understand that payment is made prior to services rendered.

Patient Signature: _____Date:_____

David S. Hernandez M.D. Pulmonologist

PATIENT NAME: _____ DATE: _____

Please complete all the following Medical History questions

Reason for today's visit:_____

How long have you experienced these symptoms? _____

DO YOU CURRENTLY USE OXYGEN? Yes _____ No _____

If yes, do you use oxygen during the DAY or NIGHT? (Please circle one)

DO YOU CURRENTLY USE A MACHINE FOR SLEEP APNEA? Yes _____ No_____

If yes, please list the name of you (DME) Durable medical equipment company that provides your OXYGEN or SLEEP APNEA MACHINE: _____

Are you allergic to any medications or food? Yes_____ No_____
If yes, Please list all of them.

Medication or food	**Reaction**

MEDICATION LIST

PATIENT NAME: _____ DOB: _____

PLEASE LIST ALL MEDICATIONS YOUA ARE CURRENTLY TAKING.

MEDICATION	DOSE	FREQUENCY

VACCINES

Please list the most recent year when you received the following vaccines:

Flu Vaccine: _____ Pneumonia Vaccine: _____

MEDICAL HISTORY:

Please circle YES or NO if you have any of these medical problems:

Asthma	Yes	No	Dementia	Yes	No
Bronchiectasis	Yes	No	Headaches	Yes	No
COPD	Yes	No	Insomnia	Yes	No
COVID-19 infection	Yes	No	Multiple Sclerosis	Yes	No
Idiopathic Pulmonary Fibrosis	Yes	No	Seizure Disorder	Yes	No
Pneumonia	Yes	No	Iron Deficiency Anemia	Yes	No
Pulmonary Embolism	Yes	No	Bone cancer	Yes	No
Sleep Apnea	Yes	No	Brain tumor	Yes	No
Heart Attack	Yes	No	Colon Cancer	Yes	No
Elevated Cholesterol	Yes	No	Leukemia	Yes	No
Congestive Heart Failure	Yes	No	Lung cancer	Yes	No
Hypertension (High Blood Pressure)	Yes	No	Lymphoma	Yes	No
Heart Murmur (Valvular Disease)	Yes	No	Melanoma	Yes	No
GERD (Acid Reflux)	Yes	No	Prostate cancer	Yes	No
Chronic Renal Failure (Kidney Disease)	Yes	No	Skin Cancer	Yes	No
Kidney Stones	Yes	No	Thyroid Cancer	Yes	No
Urinary Tract Infection	Yes	No	Renal Carcinoma	Yes	No
Rheumatoid arthritis	Yes	No	Glaucoma	Yes	No
Osteoporosis	Yes	No	Cataracts	Yes	No
Osteoarthritis	Yes	No	Bipolar disorder	Yes	No
Diabetes	Yes	No	Anxiety	Yes	No
Hyperthyroidism	Yes	No	Depression	Yes	No
Hypothyroidisms	Yes	No	Tuberculosis	Yes	No
Attention Deficit Disorder	Yes	No	Autism	Yes	No

Other medical conditions/problems (please write out):

_____

Current Medical Providers:

Please name current providers you are seen:

Primary Care Provider: _____ Cardiologist: _____

Nephrologist (Kidney): _____ ENT: _____

Neurologist (Nerves and muscles) _____ Rheumatologist: _____

Surgeries

SURGERY	YEAR	SURGERY	YEAR

Family History

Please list immediate family medical History:

	Deceased	Condition/Diagnosis
Father	Yes or No	_____
Mother	Yes or No	_____
Brother (s) Total _____	Yes or No	_____
Sister (s) Total _____	Yes or No	_____

Social History

Employment: Please Circle one: Employed Unemployed Retired

Occupation: _____

Please circle one: Single Married Separated Divorced Widowed

Number of Children: _____

Please list all hobbies and recreations: _____

Do you exercise? (Please circle one): YES NO

If yes, what type of exercise: _____

How often: _____

Have you recently traveled outside of the country? YES NO

Do you have any household pets? YES NO

If yes, how many? _____

What kind(s): _____

Tobacco/Alcohol/Supplements

Please circle YES or NO

Never Smoked YES NO

Current Smoker, everyday YES NO # of Cigarettes _____ or # of Cigars _____

Current Smoker, some days: YES NO # of Cigarettes _____ or # of Cigars _____

Pks/day_____ Quit Date_____

Alcohol Use: YES NO

Social Drinker: YES NO

Heavy Drinker: YES NO Quantity: _____

Moderate Drinker: YES NO Quantity _____

Type of alcohol: Beer Wine Mixed Drinks Hard Liquor

Caffeine or Coffee: YES NO Servings per day_____

Substance Abuse

Do you or have you used illicit substances? YES NO

If yes, please list drugs used: _____

I certify that the information provided in this medical history form is true to the best of my knowledge.

Patient Signature: _____ Date _____

Name: _____ Date: _____

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0 = no chance of dozing, to 3 = high chance of dozing. When you finish the test, add up the value of your response. Your total is based on a scale of 0-24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How sleepy are you?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tires. Even if you have done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- **No chance of dozing = 0**
- **Slight chance of dozing = 1**
- **Moderate chance of dozing = 2**
- **High chance of dozing = 3**

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and Reading	•
Watching TV	•
Sitting inactive in a public place (ex: a theater or a meeting)	•
As a passenger in a car for an hour without a break	•
Lying down to rest in the afternoon when circumstances permit	•
Sitting and talking to someone	•
Sitting quietly after lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score: _____

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.

8-9: You have an average amount of daytime sleepiness.

10-15 You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.

15-24 You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness; The Epworth Sleepiness Scale. Sleep 1991; 14(6):540-5

AUTHORIZATION FOR RELEASE OF INFORMATION

*Patient's Name: _____ *DOB ____/____/____ SSN: _____

*Address:_____ *Telephone: _____

I authorize the facility named below to release information from my or the patient's health records to the facility or person indicated. I understand any treatment or payment for that treatment is not dependent on my signing of this release. I understand I may receive a copy of this release form if I desire one.

To be released by:

_____

_____

_____

_____

*To be released to:

David S. Hernandez, M.D.

1619 E. Common St., Suite 902

New Braunfels, TX 78130

Tel: (830) 214.0104 Fax: (830) 358.7371

*List date(s) or treatment to be released:

_____

***The information to be released from each visit is limited to:**

[ ] Lab test
[ ] Last PFT
[ ] Overnight Pulse Ox
[ ] Other (specify)

[ ] Last Sleep Study
[ ] Last CT
[ ] Last (2) Doctor's Notes

[ ] Demographics
[ ] 6 Minute Walk
[ ] Last X-ray

_____

* **The information is being released for the following purpose:**

[ ] Continued medical evaluation, Appt. Date _____
[ ] Personal use (fees apply)
[ ] Other (specify)

[ ]Third party payment/insurance (fees apply)
[ ] Legal consultation (fees apply)

_____

Any other use of release to another party without the written permission of the patient or the patient's authorized agent is Prohibited. However, I understand that no guarantee as to the confidentiality of this information can be made once it is released I understand that this authorization may be revoked at any time in writing, except to the extent that information has already been released and that revocation should be sent to the above entity at the above address. I hereby release any individual or organization disclosing the information contained in this patient's record from any liability if performed within the limits of this authorization.

***I understand that my records may contain information protected under State & Federal privacy laws including results of HIV testing or treatment and/or information regarding drug, alcohol or psychiatric treatment & I especially authorize the release of this information to the above-named recipient.**

*_____ *_____

Signature of Patient or Legal Representative **Date**

*_____ *_____

Relationship of Above Signer if Other Than Patient **Witness Signature**

***Denotes Required Elements. This form must be completely filled out to be valid.**

Medical Release & Assignment of Benefits

Date: _____

Name: _____ DOB: _____

I authorized the release of medical information necessary to process payment for services rendered. I authorize Dr. Hernandez to submit claims to my medical insurance on my behalf for services rendered by him. I request that insurance payment be made directly to Dr. Hernandez. I permit a copy of this authorization to be used in place of the original.

Signature:_____ Date:_____

I understand that I am responsible for payment of any services rendered to me or my dependent(s) provided by this office. I understand that I am responsible for any service my insurance plan deems non-covered, all coinsurance, co-payments, deductibles, and any amount that exceeds benefits.

Signature:_____ Date: _____

I acknowledge having received this office's NOTICE OF PRIVACY PRACTICES explaining how my medical information will be used or disclosed.

Signature: _____ Date:_____

****

MY MEDICAL INFORMATION MAY BE RELEASED TO THE FOLLOWING FAMILY MEMBERS

Name	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____

Our Financial and Office Policies

We appreciate you choosing Dr. David S. Hernandez for your pulmonary and sleep care. Our utmost priority is delivering exceptional medical care to our patients. Before consulting with the physician, we kindly request that all responsible individuals carefully read and sign our financial/office policies.

1. All co-pays, deductibles, and/or co-insurances are due at the time of service. We do not choose these fees. They are provided to our office by your insurance company when we call to verify benefits and/or the terms agreed upon by you (or your employer) and your insurance company. We will collect all co-payments, deductibles or charges for non-covered services at the time upon check-in. If you have a balance on your account we will ask for that payment in full as well. For your convenience, we accept cash, check, Visa, MasterCard, American Express and Discover.

2. We verify insurance benefits as a courtesy to our patients. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in your medical plan. Some insurance companies select certain services they will not cover. Please contact your insurance company if you have any questions regarding your health care coverage. Dr. David S. Hernandez provides services that are medically necessary in the physician's professional opinion. If you are unsure if a procedure is covered, please call your insurance company prior to receiving services. You are ultimately responsible for all charges that are not covered under your health care policy.

*If your insurance company pays only a portion of a bill or rejects your claim, the policy holder should contact the insurance company for a detailed explanation. Reduction of rejection of any claim by your insurance company does not relieve you of your obligation. In the event that your insurance company pays us for a claim that you had already paid and you are due a refund, we will be happy to expedite your refund or credit your account

3. Please ensure that all personal and insurance information is correct at each visit. We will only bill the insurance company on file. If a claim is rejected or left outstanding due to incorrect insurance information, you will be responsible for the visit. It is not uncommon for someone to change their phone number or address and forget to inform us. This leads to fragmented communication. Please inform the receptionist if your address, phone number, or insurance information has changed (or if you anticipate that it will be changing in the near future.)

4. Some insurance companies require a referral from your primary care physician before being seen by Dr. David S. Hernandez. If your appointment requires a referral from your primary care physician, that referral will need to be on file with our office before the next appointment day. If you are seen without a referral form on file and the insurance company does not pay, you will be responsible for all charges.

5. We allow 90 days for payment of any balances that are the responsibility of the patient. If we do not receive full payment in 90 days, your account will be sent to collections. We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems to us, so that we may assist you to keep your account in good standing.

6. If your personal check is returned for insufficient funds, there is a $50.00 charge in addition to the amount of the check. After one instance of a returned check, all further payment will be required to be in the form of credit card, cash or money order only.

7. Dr. David S. Hernandez does NOT complete any FMLA, Disability, Extended Work Excuse or any paperwork/forms requiring the completion by provider. Please contact your primary care provider regarding the completion of these forms.

8. There is a $45 fee for the completion of handicap parking plaque paperwork. For the signing of any letters such as military exemptions there is a $70 fee. If you have any questions regarding if Dr. David S. Hernandez can sign paperwork/letters brought in by the patient please ask the receptionist and they will confirm.

9. There is a $1.00 fee per page for copies of medical records. We can fax records free of charge to another provider after we have received the Release of Medical Records Form.

10. Appointments not canceled with a 24 hour notice, same day cancellation/reschedule and any “No Show” appointments will be subject to a fee of $50.00. Patients will not be given a new appointment until the fee is paid. Please note that this fee is not covered by your insurance company. We sincerely hope that we will not need to collect this fee. Rather, it is offered as an incentive to remind all of our patients and families to keep their scheduled appointments or, if unable to keep that appointment, to please reschedule more than a 24 hours in advance (and we greatly appreciate 48-72 hours advance notice.) When you reschedule your appointment several days ahead of time, this allows other patients the opportunity to be seen sooner.

11. If you are more than 15 minutes late for your appointment and have not called the office to inform us, we will reschedule your appointment and you will be subject to a $50.00 no-show fee as stated in policy #10 above.

12. After 3 “No Show” appointments we reserve the right to terminate the physician/patient relationship. A notification will be sent to the responsible party and to the referring physician.

13. ALL prescription refills MUST be called to your pharmacy. You can have your pharmacy submit the refill request electronically, or they may fax the request to 830-358-7371. Please do not wait until you are out of medication to ask your pharmacy for a refill or call our office. We require 2 business days to respond to a refill request. Please note that we do not process refill requests on weekends or holidays. The patient must have a follow-up appointment scheduled or have been seen within the last 6 months in order to have any prescription refilled.

14. Dr. David S. Hernandez does NOT write prescriptions for controlled substances.

Patient Name (printed): _____

Patient Signature: _____

Date: _____

Office Policies

ASSIGNMENT OF INSURANCE BENEFITS:
I authorize payment of benefits to be paid directly to the affiliated providers of DAVID S. HERNANDEZ, M.D., P.A. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment. Regarding those with coverage through Medicaid, I understand that DAVID S. HERNANDEZ, M.D., P.A. is accepting me as a private pay patient and I will be responsible for paying for any services that I receive. A claim will not be filed to Medicaid for the services that are provided.

CONSENT FOR TREATMENT:
I hereby authorize DAVID S. HERNANDEZ, M.D., P.A. and affiliated providers to perform a physical examination and to provide any medical treatment deemed necessary. This includes but is not limited to all required medical examinations, echocardiograms, EKG, nuclear scans, x-rays, and/or medical and surgical procedures.

PATIENT PAYMENT RESPONSIBILITY:
I hereby agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered.

APPOINTMENT CANCELLATIONS:
I hereby agree to make every attempt to call the office within 24 hours in advance of any appointment that needs to be canceled or rescheduled. If I fail to contact the office within this time period I hereby agree to pay a $50 no-show fee.

CHANGE OF INFORMATION:
I hereby agree to provide the office any information regarding changes in my address, phone number, health benefits, or insurance information.

NOTICE OF PRIVACY PRACTICES:
DAVID S. HERNANDEZ, M.D., P.A. and affiliated providers are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgment of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:
I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that DAVID S. HERNANDEZ, M.D., P.A. and affiliated providers reserve the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

Patient Name (printed): _____

Patient Signature: _____

Date: _____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of DAVID S. HERNANDEZ, M.D., P.A. and affiliated providers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of DAVID S. HERNANDEZ, M.D., P.A. and affiliated providers reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of DAVID S. HERNANDEZ, M.D., P.A. and affiliated providers may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of DAVID S. HERNANDEZ, M.D., P.A. and affiliated providers may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of DAVID S. HERNANDEZ, M.D., P.A. and affiliated providers may email to my home or other alternative location any time that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of DAVID S. HERNANDEZ, M.D., P.A. and affiliated providers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of DAVID S. HERNANDEZ, M.D., P.A. and affiliated providers may use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of DAVID S. HERNANDEZ, M.D., P.A. and affiliated providers may decline to provide treatment to me.

Patient Name (printed): _____

Patient Signature: _____

Date: _____